



Strengthen Medicare. Don't End It.

Medicare provides health and financial security to 48 million older and disabled Americans, and it provides us all with the security of knowing that our relatives will be protected from unforeseeable risks in old age or disability. With private pensions evaporating and personal savings eroding in the midst of an economic crisis, Medicare is more vital than ever. “Premium support” would privatize Medicare and end Medicare as we know it, both by eliminating the Medicare guarantee and shifting huge costs to enrollees.

Medicare works, and we need to keep it strong for future generations. The Affordable Care Act (ACA) has already made several changes that make Medicare both more cost effective and better insurance for seniors.

- The ACA will save taxpayers more than \$200 billion by 2016, resulting in an immediate benefit to the Trust Fund. None of these savings come from shifting costs to seniors. Most will be achieved by ending overpayments to private insurers and paying doctors for doing good work instead of just more work.¹
- The ACA improved Medicare’s long-term financial outlook. Medicare’s Trust Fund is fully funded for the next 12 years, while the historical average projected lifespan of the fund is 11.3 years.² Efforts to repeal the ACA weaken Medicare’s financial outlook.
- In 2011, seniors who reach the prescription drug coverage gap, or doughnut hole, will receive a 50 percent discount when buying Medicare Part D covered brand-name prescription drugs. Over the next 10 years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed for good in 2020.³
- The law provides certain preventive services, such as annual wellness visits, tobacco cessation counseling, preventive screenings, and personalized prevention plans, at no cost for seniors on Medicare.⁴
- The ACA established a new Center for Medicare & Medicaid Innovation that will begin testing new ways to buy and deliver care that improve quality while lowering costs.⁵
- The law established the Community Care Transitions Program, which helps high-risk hospitalized Medicare beneficiaries avoid unnecessary readmissions by coordinating care and connecting patients to community-based services.⁶

¹ Center for Medicare and Medicaid Services, “The Affordable Care Act: Lowering Medicare Costs by Improving Care”. 2012

² Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 1970-2011.

³ US Department of Health and Human Services, “The Healthcare Timeline” 2012

⁴ US Department of Health and Human Services, “The Healthcare Timeline” 2012

⁵ US Department of Health and Human Services, “The Healthcare Timeline” 2012

⁶ US Department of Health and Human Services, “The Healthcare Timeline” 2012

It is misleading to say that Medicare is “bankrupt.”

- After 2024, revenue still will be able to cover about 87% of Hospital Insurance costs.⁷ Physician and outpatient services and the prescription drug benefit are not – and cannot – be insolvent. There is a shortfall in Hospital Insurance funding, but it is disingenuous and deceptive to scare seniors by saying that Medicare is “bankrupt.”

Private insurance is hardly an appropriate model for Medicare’s future. Private insurance has proved itself far less effective in controlling costs.

- Unlike private insurance, Medicare’s per-capita costs are growing at the same pace as GDP.⁸
- On average, per capita costs have risen 1% less in Medicare than in private insurance each year since 1970. That means private insurance premiums have risen almost 60 percent faster than Medicare’s per capita costs.⁹
- The CBO projects that privatizing Medicare would lead health care costs to be 60 percent higher for a typical 65-year old by 2035.¹⁰
- Private insurers concede they cannot control costs.¹¹ The cost of health coverage has outstripped the growth of wages, eating into family income.¹² Many employers are cutting benefits and raising co-pays or eliminating coverage altogether.¹³ This is why the Affordable Care Act is so important to families.
- Over the next decade, private insurance premiums are projected to rise nearly 50 percent faster than the per capita cost of Medicare each year.¹⁴

Since Medicare is more efficient than private insurers, the only way a premium support system can save money for the government would be by shifting costs to older and disabled Americans.

- “Premium support” shifts costs to enrollees.¹⁵
- The voucher plan proposed in Budget Committee Chairman Paul Ryan’s latest budget controls spending by cutting the value of the voucher.¹⁶

⁷ Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2012 Annual Report*, April 23, 2012.

⁸ John Holahan and Stacey McMorrow. “[Medicare, Medicaid, and the Deficit: Timely Analysis of Immediate Health Policy Issues](#).” Urban Institute, April 2012.

⁹ CMS, *NHE Web Tables* (Washington, DC: 2009), Table 13.

¹⁰ CBO, *Long-Term Analysis of a Budget Proposal by Chairman Ryan* (Washington, DC: Apr. 5, 2011), 22.

¹¹ <http://www.help.senate.gov/imo/media/doc/Ignagni3.pdf>

¹² For income figures, see *Current Population Survey, Annual Social and Economic Supplements*, Sept. 2011, Table 8. For insurance costs, see Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2011 Annual Survey*, 69.

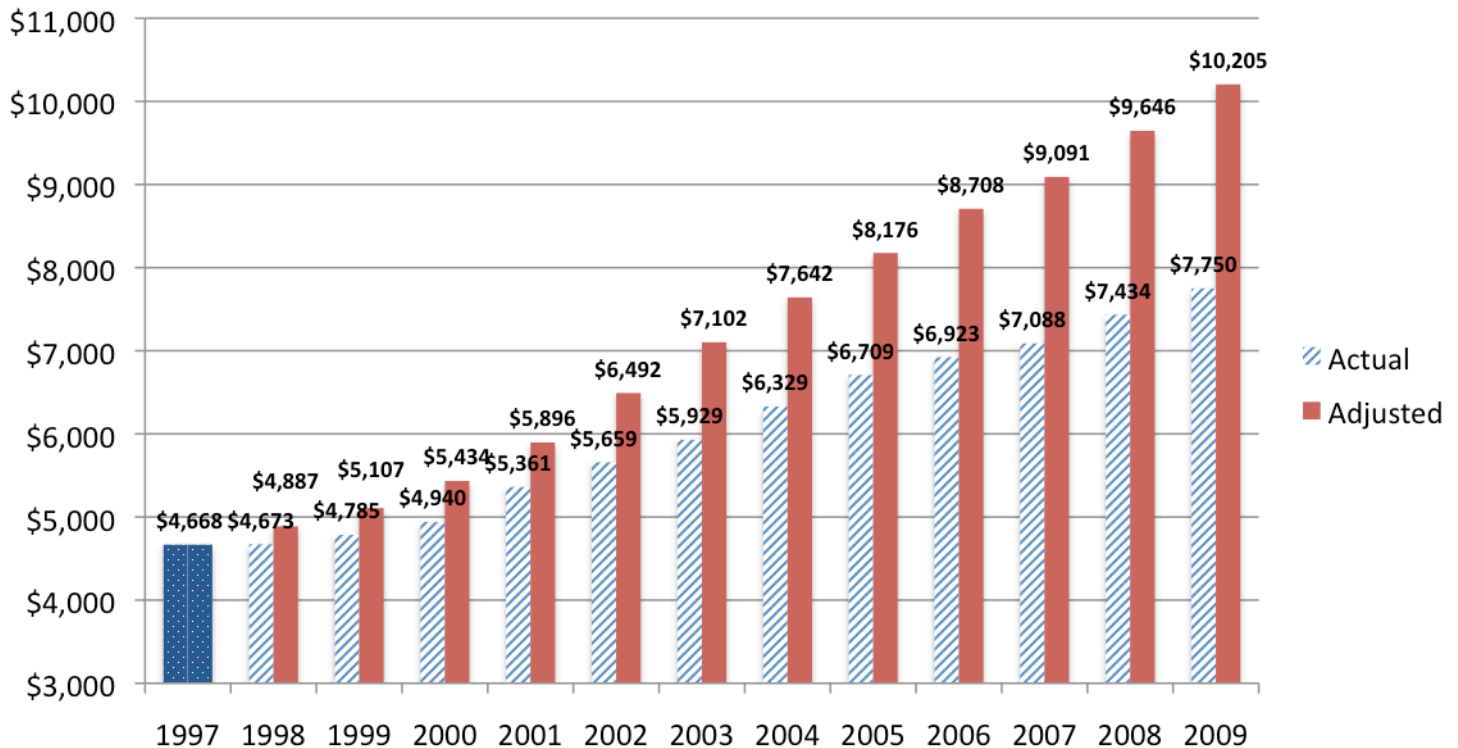
¹³ Commonwealth Fund, *State-Level Trends in Employer-Sponsored Health Insurance: A State-by-State Analysis*, June 2011.

¹⁴ For total benefits. CMS, *National Health Expenditure Projection, 2010-2020* (2011), Table 17.

¹⁵ Henry J. Aaron and Robert D. Reischauer, “The Medicare Reform Debate: What Is the Next Step?,” *Health Affairs*, 14(4): 8-30 (Winter 1995).

¹⁶ Van de Water, Paul N. “[Ryan-Wyden Premium Support Proposal Not What It May Seem](#).” Center for Budget and Policy Priorities. Dec 21, 2011.

Annual Medicare Per-Capita Spending, 1997-2009, *Actual Spending vs. Hypothetical Spending at Private Health Insurance Growth Rates*



In order to get a handle on skyrocketing health care costs, we need to develop new health care delivery systems that coordinate care for the people with the highest costs and create new payment methods that reward value, not volume. **Medicare is essential to driving needed reforms because it gives policymakers the means to encourage providers to adopt best practices. No private health insurance company has the influence that Medicare has to change these practices.**

- Medicare has a history of driving innovations later adopted throughout the health care sector. For example, Medicare's fee schedule, adopted in the 1980s to prevent providers from setting exorbitant rates, is the basis for prices throughout the system.¹⁷
- The Affordable Care Act gave Medicare the mandate and the resources to develop pilot programs to test the effectiveness of different system reforms, which create financial incentives for providers to improve care while controlling costs.
- Developing reliable measures of what works and what doesn't is key to long-term savings, but it's a long-term process that's just beginning.¹⁸ Insurance companies are prevented by

¹⁷ Uwe Reinhardt, ["How Medicare Pays Physicians,"](#) New York Times, December 2010.

competitive imperatives and short-term thinking from making long-term commitments to studying the health system or to sharing findings with rivals.

Medicare covers a population that would have extreme difficulty shopping for coverage.

- Surveys show that 29% of seniors have “below basic” health literacy, meaning they lack the “capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”¹⁹
- Nearly one-third of Medicare enrollees have some sort of a cognitive impairment.²⁰

Commercial insurers’ business model is built on denying coverage to the most vulnerable.

- Commercial insurers are likely to engage in a practice known as “risk-selection” or “cream skimming.” Insurers design benefits in ways that do not meet the needs of the sickest individuals, steering the most vulnerable into public programs, a practice that becomes increasingly unaffordable because it covers a very risky population. This creates a two-tiered health care system: a low-cost one for the healthy, and an extremely expensive one for the sick.^{21,22}
- The government can try to address adverse risk-selection by making enhanced “risk-adjustment” payments designed to shield health plans from the costs of covering the most vulnerable, but Medicare Advantage plans have proved adept at gaming this system.²³

Our parents and grandparents built the Medicare system, and hundreds of millions of Americans were well-served by it over the last half century. Now it’s our job to strengthen Medicare for future generations, not break it into pieces and turn it over to the insurance industry. Congress has the power to ensure that Medicare remains financially sound. Congress has a range of ways to trim Medicare’s costs, reduce waste and inefficiencies, and raise additional revenue to save public funds without privatizing Medicare and shifting more costs to vulnerable Americans.

¹⁸ CBO, Lessons from Medicare’s Demonstration projects on Disease Management, Coordinated Care, and Value-Based Payment. January 18, 2012.

¹⁹ National Center for Education Statistics, “The Health Literacy of America’s Adults: Results from the 2003 National Assessment of Adult Literacy.” September 2006.

²⁰ Kaiser Medicare Chartbook, 2010, 4th Edition. Figure 1.7.

²¹ Van de Water, Paul N. “[Converting Medicare to Premium Support would Likely Lead to Two-Tier Health Care System.](#)” Center for Budget and Policy Priorities. Sept. 26, 2011.

²² Aaron, Henry and Austin Frakt. “[Why Now Is Not the Time for Premium Support](#)” New England Journal of Medicine, March 8, 2012.

²³ Jason Brown, Mark Duggan, Ilyana Kuziemko, and William Woolston, “[How does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program.](#)” NBER Working Paper No. 16977, April 2011.